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PHYSICIANS PREFERENCES BIAS TREATMENT CHOICE FOR DEEP VEinous THROMBOSIS

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Deep vein thrombosis (DVT) can be treated with a thrombolytic drug (often streptokinase) followed by anticoagulant therapy. When compared with untreated patients, it reduces the incidence of postthrombotic syndrome (PTS). However, it increases the risk of bleeding, stroke, and death. A recent article in N Engl J Med 1995:333:1864-9, using decision analysis, O'Meara et al. suggested that patient preferences influence the decision to use anticoagulation alone in the treatment of deep vein thrombosis in patients with no history of health and knowledge of relevant health states. We hypothesized that, given a realistic description of the morbidity of PTS, many younger patients would prefer treatments consistent with use of streptokinase followed by intravenous heparin. However, the most common treatment for DVT favors the use of heparin alone, which reflects the physicians' values for ictogenic events rather than patient preferences.

We developed a multimedia utility assessment program that describes mild and severe PTS, and some alternative treatments. We administered this program to 20 respondents from the Stanford Faculty, and then calculated the expected number of QALYs using O'Meara's decision model. We found that younger patients, who have a higher risk of PTS, would prefer a treatment that minimizes the risk of PTS but also increases the risk of stroke/death. Using their utilities for PTSD and responses to a clinical problem in which they traded a 1% risk of stroke/death from the use of streptokinase for varying gains from prevention of PTS.

Results. In general no significant differences were found between the patients and the control group, between the patients who were treated by RT and patients who were treated by S+ as primary treatment.

In the second interview, the respondents were instructed to use the time trade-off method, whereafter the utilities for two treatment modalities (RT vs S+) were elicited. Additionally, we differentiated the differences on these measures between the patients who were treated by RT and patients who were treated by S+ as primary treatment.

Conclusion. In general, we did not find significant differences between the patients and the control group. No relation was found between QOL and treatment choice.

DISEASE-SPECIFIC HEALTH STATES: DETERMINING CRITERIA FOR OPTIMAL INSTRUMENT CONSTRUCTION. COST AND QUALITY OF LIFE MEASUREMENTS

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The use of health states has become an essential cornerstone for many cost-utility and quality of life analyses. One of the main difficulties and questions raised by investigators is: Which state should be used in describing health states? This question becomes even more complex in the case of diseases with a large number of health states like cancer, heart disease, diabetes, etc. This study presents a methodology used to generate health states that are not only useful but also tailored for the research objectives. The use of disease-specific health states for use in health utility assessments. This methodology includes the following: 1) a qualitative discussion of objective and subjective criteria for classification; 2) recommended psychometric properties involving stage, quality and quality of life; and 3) Stage classification for instrument construction which allow for flexible selection of states based on a post-hoc evaluation of classification futility in a study. In addition, we present a worked example of an instrument developed for evaluating health states of elderly women with early stage breast cancer. Using SP-36 data from a study of 260 hospitalized elderly, we present a cluster analysis which assisted in selecting key attributes that highly discriminate between elderly individuals. The analysis indicated that the data is characterized by seven clusters. Within each cluster, one or two questionnaire items showed superior discriminating power.

OBJECTIVE: To explore the role of a physician's own ethnicity, gender and type of medical practice in making management of health state information. METHODS: A cross-sectional survey, administered to physicians working in inner-city community health clinics, measured attitudinal and gender differences in the management of health state information. RESULTS: African-American physicians had the most positive orientation toward management of health state information and Hispanic physicians had the most negative (p<0.05) with white and Asian-Americans between. Logistic regression analysis suggested that gender differences in the management of health state information were mainly influenced by treatment and disease related knowledge. The mechanisms for these changes, especially the effects of education, are not yet clear.